Galesburg Cottage Hospital
695 N. Kellogg St.
Galesburg, IL 61401

Patient Name:	**SHIELDS, EARNEST D**	**Room Number:**	**EOP**
Medical Record #:	**418894**	**Patient Number:**	**5290082**
Date of Service:	**06/16/2008**	**DOB/SEX:**	**2/19/1971 / M**
Ordering Physician:	**BOMMIASAMY VEERASIKKU MD**	**Admitting Physician:**	**BOMMIASAMY VEERASIKKU MD**

RADIOLOGY REPORT

MAGNETIC RESONANCE IMAGING OF THE LEFT SHOULDER

HISTORY: The patient was weight-lifting today and heard a "pop" resulting in limited range of motion and pair in the shoulder joint.

TECHNIQUE: Sequences as listed.

FINDINGS: There is moderate increase in signal intensity within the distal supraspinatus - rotator cuff tendon, compatible with moderate tendinosis and/or partial tear. There was no abnormal fluid within the glenohumeral joint or subacromial - subdeltoid bursa. The glenoid labrum appears intact. Marrow space signal intensity of the visualized humeral head and glenoid process appear within normal limits. The bicipital tendon appeared within the bicipital groove.

SUMMARY:

MODERATE TENDINOSIS AND/OR PARTIAL THICKNESS TEAR SUPRASPINATUS - ROTATOR CUFF TENDON. MILD DEGENERATIVE CHANGES LEFT ACROMIOCLAVICULAR JOINT WITH MINIMAL INDENTATION ON THE ROTATOR CUFF MUSCULOTENDINOUS STRUCTURES.

STEPHEN LEHNERT MD

Electronically Signed on 6/17/2008 1:40:38 PM by Stephen LehnertMD

06/23/08 EARNEST SHIELDS 111453.0

This 34 year old is a prisoner at Henry Hill Correctional Center. He was lifting weights on 06/18/08 when a weight dropped and he injured his left chest. He felt something snap. He has had ecchymosis of the left proximal humeral area and lateral chest near the axilla on the left side. He is complaining of constant pain, worse with activity.

Past Medical History: The patient has had a gunshot wound in the past.
Medications: Motrin.
Allergies: None.
Family History: Not contributory to this problem.
Social History: Habits: tobacco and alcohol – none. The patient is a prisoner.
Review of Systems: No other complaints voiced.

Physical Examination: The patient is 5'8" and weighs 185 pounds. The left shoulder shows ecchymosis of the proximal humerus and the axilla. There is tenderness of the pectoralis insertion. There is an obvious rupture of the pectoralis tendon. The patient has weakness of adduction of the left shoulder. He has pain with passive abduction.

Assessment: Pectoralis tendon rupture left shoulder.

Plan: This injury requires treatment by a shoulder specialist. I do not have the expertise to perform the surgery necessary to treat this problem.

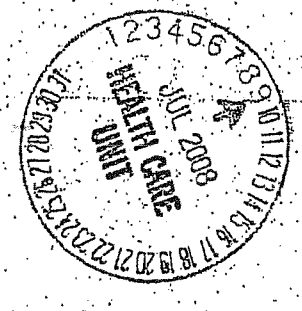
Gregory A. Schierer, M.D./jlh

GAS 8/14/08

GALESBURG ORTHOPEDIC SERVICES, LTD

MICHAEL L. GERNANT, M.D.
GREGORY A. SCHIERER, M.D.
KENNETH L. BUSSEY, M.D.

June 23, 2008



Henry Hill Correctional Center
Dr. Shute
600 Linwood Road
Galesburg, IL 61401

REF: EARNEST SHIELDS B66161

Dear Dr. Shute:

Enclosed are my office notes of 06/23/08 concerning Earnest Shields. He has a pectoralis tendon rupture of the left chest and shoulder. He needs to see a shoulder specialist for surgery. I have not performed this surgery in the past.

If you have any questions, please contact me.

Sincerely,

Greg Schierer MD

Gregory A. Schierer, M.D.
GAS/jlh

Enclosure

DATE: 7/14/08
TIME REC:
INITIAL DATE: JM

Exh 4

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Gregory A. Schierer, M.D./jlh

8/11/08

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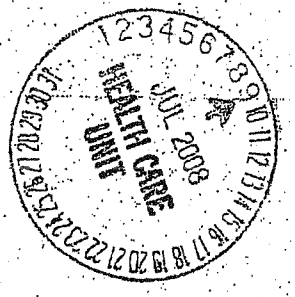
June 23, 2008



Henry Hill Correctional Center
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600 Linwood Road
Galesburg, IL 61401

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If you have any questions, please contact me.

Sincerely,

Greg Schierer MD

Gregory A. Schierer, M.D.
GAS/jlh

Enclosure

DATE: 7/14/08
TIME REC:
INITIAL DATE: JM

Medical Furl. 10-9-08 LT-8:30am

ILLINOIS DEPARTMENT OF CORRECTIONS
Offender Health Status Transfer Summary

Transferring Facility: Hill Center

Offender Information: Shields (Last Name) Earnest (First Name) MI ID#: B6619

Date: 10.7.08 Time: 8 ☐ a.m. ☒ p.m.

Transfer Screening (completed by transferring facility health care staff): ☐ HIV Test & Counseling Offered (only transfers to ATC, parole, release or discharge)

Allergies: NKA
Food Handler Approved:
Current / Acute Conditions / Problems: L shoulder pectoral tendon rupture
Chronic Conditions / Problems:

Current Medications (name, dosage, frequency, and duration):
Acute Short-term: Ø
Chronic Long-term: Ø
Chronic Psychotropic: Ø

Current Treatments: Ø
Therapeutic Diets: Ø
Follow-Up Care: Proper med follow up
Chronic Clinics: Ø
Specialty Referrals: P.T., Cottage Rehab
Significant Medical History: Ø GSW L foot/ankle, depression
Physical Disabilities / Limitations: Ø
Assistive Devices / Prosthetics: Ø ☐ Glasses ☐ Dentures
Mental Health Issues: ☐ Hx Suicide Attempt: Date: / / ☐ Hx Psych Med ☐ Hx MPC / STC Substance Abuse: ☐ Alcohol ☐ Drugs

HCU Use Only: ☐ LAB ☐ EKG ☐ CXR ☐ Dental ☐ MEDS ☐ MH ☐ Other: ☐ Packet Complete

D Clark RN (Print Name and Title) D Clark (Signature) 10.7.08 (Date)

Reception Screening (completed by receiving facility health care staff):

Facility: Date: / / Time: ☐ a.m. ☐ p.m.
Subjective: Assessment:
Current Complaint:
Current Medications/Treatment:
Objective:
Physical Appearance/Behavior:
Deformities: Acute/Chronic:
T: P: R: B/P: /

Plan: Disposition:
☐ Health Information Given ☐ Emergency Referral:
☐ Sick Call: Urgent / Routine
☐ Medication Evaluation ☐ Therapeutic Diet ☐ Special Housing ☐ Chronic Clinics
☐ Work / Program Limitation ☐ Specialty Referrals ☐ Other (specify):
☐ Infirmary Placement:
☐ HIV Test & Counseling Offered (only transfers from R&C)
☐ Other (specify):

Printed Name and Title Signature / / Date

Adult Transition Center transfers only:

I understand that medical and dental care are my responsibility while I am housed in a transition center. I also understand that if I am in need of health care and I cannot afford it, I may be transferred back into a facility within the Department that can provide my medical, mental health, or dental needs.

Offender's Signature Date Time ☐ a.m. ☐ p.m.

Distribution: Offender's Medical Record; Transferring Facility; Receiving Facility

DOC 0090 (Rev. 1/2006)

Cottage
Rehabilitation & Sports Medicine

GAL

PATIENT REGISTRATION FORM

PATIENT INFORMATION

REGISTRATION DATE: 10908

Name: First name: Ernest M.I.: D. Last name: Shields Sex: (M) F

Address: 600 Linwood Rd Spouse's name: NONE

City: Galesburg State: IL Zip Code: 61401

Employer: Incarcerated Hill C.C. Occupation:

Address: Employer phone #: ( ) -

City: State: Zip Code:

Home Phone ( ) - Work Phone ( ) -

Date of Birth: 2/19/73 Social Security #: UNKNOWN

Drivers License #: UNKNOWN State of Issue:

REASON FOR VISIT: Shoulder + Chest Inj. DATE OF INJURY: 7/16/8

Referring Physician: Dr Migliorino

Type of Injury ( ) General Health ( ) Personal Liability ( ) Work Comp ( ) Motor Vehicle ( ) Other

Did the Injury Occur at Your Workplace? If So, has Your Employer Been Notified?

Are you represented by an attorney? If so, Name of attorney

Have You Received Therapy Services during the Current Calendar Year? If so, who provided services

Have You Received Any In-Home Services Within the last 30 Days? If so, who provided services

RESPONSIBLE PARTY INFORMATION

PERSONS RESPONSIBLE FOR BILL

Name: Wexford Services

Relationship to Patient:

Date of Birth: Social Security #:

Address:

City: State: Zip Code:

Home Phone ( ) - Work Phone ( ) -

INSURANCE INFORMATION

PLEASE MAKE AVAILABLE THE APPLICABLE INSURANCE CARDS

Primary Insurance Carrier: ( ) Private Policy ( ) Group Policy w/ Employer

Group # Policy or Subscriber Id#

Name of Insured Insured Date of Birth / /

Secondary Insurance Carrier: ( ) Private Policy ( ) Group Policy w/ Employer

Group # Policy or Subscriber Id#

Name of Insured Insured Date of Birth / /

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Advanced Physical Therapy Service, Ltd for their services. I understand that I am financially responsible for any balances, including Attorney and Collection fees in the event of my default.

X Ernest Shields

Patient / Guardian Signature Date 10/9/8

Cottage
Rehabilitation & Sports Medicine

765 North Kellogg Street
Galesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

SENT TO DOCTOR

PHYSICAL THERAPY INITIAL EVALUATION

Name: Ernest Shields
Physician: Dr. Migliorino
Diagnosis: tear of (L) Pectoralis
Onset Date: 7/16/08
D.O.B.: 2/19/1973
Medications: Pain med, ASA
Physician Orders: PT Eval and Treat x 3 visits

SUBJECTIVE INFORMATION:

History: Medical: No other PMH noted.

Previous Functional Level: unk functional level pre-injury

Mechanism / History of Injury: Pt reports that he tore his (L) pectoralis muscle while attempting to bench 365#. He feels that therapy is not going to help and he needs surgery
Vocational Considerations:

Current Complaints: pain + to chest, numbness (L) side of chest + to entire arm from movement
Functional Limitations: overhead, weakness ~ ADLs, pain at night
Pain Level (0-10 Scale): 10/10 Worst
Location: (L) pec
Previous Treatments: N/A per pt report
Test Results: Prior MRI + x-ray confirmed diagnosis.
Patient Goals: Pt wants surgery to fix the pec muscle and respectfully does not feel that PT will benefit him significantly.

OBJECTIVE INFORMATION:

Appearance: Obvious atrophy of (L) pec mm near the shoulder/insertion
Palpation: Elicits tenderness (L) pec mm mid belly ~ significant tightness.
AROM: Sh Flexion (L) 132° (R) 164° Sh ABD (L) 142° (R) 164°
PROM: Sh Flexion (L) ~100° guarding Sh ABD (L) 100° guarding Sh IR (L) 70° Sh ER (L) 86°
Strength: Sh Flexion (L) ~~3/5~~ 4/5 Sh ABD (L) 4/5 Sh ER (L) 4/5 Sh IR (L) 4/5 Pec (L) 3/5*
(R) 5/5 (R) 5/5 (L) 5/5 (R) 5/5 (L) 5/5

Gait: WFL
Posture: ABducted, dummardly rotated scapula (L); forward (L) shoulder
Sensation: Not formally assessed.
Special Tests:
N/A.

Cottage
Rehabilitation & Sports Medicine

765 North Kellogg Street
Galesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

PHYSICAL THERAPY INITIAL EVALUATION (CONTINUED)

Name: Earnest Shields

ASSESSMENT:

35 y.o. Dx c diagnosis of (L) Pectoralis tear demonstrating an obvious deformity in the (L) pec muscle, pain/abicited tenderness as noted, limited B/AROM, ↓d strength and ↓d functional activity tolerance. The pt. would benefit from contd PT x 3 more visits per MD order to address the above noted deficits and below stated goals

TREATMENT PLAN:

Goals:

STG: 1-2 visits

1. (E) c HEP as appropriate.
2. ↓ pain at worst to ≤ 5/10 at worst

LTG: 3 visits

1. Demo L=R Shoulder AROM
2. Demo. ≥ 4/5 strength (L) pec and ≥ 4/5 Sh flexion.
3. Demonstrate functional improvement of the (L) SL/UE.
4. ≤ 3/10 (L) chest/pec pain/discomfort at worst

Rehab Potential:

☐ Excellent ☐ Good ☒ Fair (For Above Goals) ☐ Poor

Treatment Orders: Therex, MT, Modalities PRN

Today's Treatment: MT including AROM SL Flex, ABD, ER and IR to tolerance, TE HEP issued per 10/9/08 HEP c pt performance.

Procedure/Mins: TEX 17 Total Treatment Mins: 17

Treatment Frequency: 1x (every 2 weeks) Expected Duration: 3 visits (6 weeks)

Certification Period (Medicare): N/A

Discharge Plan: When PT goals are met

Therapist's Signature: Jason Standre MS, PT Date: 10/9/08

- Medicare recipients require signature of physician. Non-Medicare recipients require print of physician's name.

Physician: _____ Date: _____

Illinois
Department of
Corrections

Rod R. Blagojevich
Governor

Roger E. Walker Jr.
Director

Hill Correctional Center / 600 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 343-4212 / TDD: (800) 526-0844

MEMORANDUM

DATE: October 6, 2008

TO: Infirmary Staff

FROM: Lois Lindorff, RN/HCUA

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest NUMBER: B66161 D.O.B.- 2/19/73
DATE: 10/9/08 LEAVE TIME: 8:30a.m.

REFERRING PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: Physical Therapy (1st visit).

LOCATION: Cottage Rehab & Physical Therapy
STREET: 765 N. Kellogg Street/Suite 300
CITY/STATE/ZIP: Galesburg, Il 61401
PHONE NUMBER: (309) 343-3434

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report – Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

Prep Needed: **None.**

Cc: 7/3 Shift Commanders
Records Office
x-ray
medical file
file

Cottage
Rehabilitation & Sports Medicine

The DASH

DISABILITIES OF THE ARM, SHOULDER, AND HAND

Patient Name Ernest Shields Date 10/9/8

INSTRUCTIONS: This questionnaire asks about your symptoms as well as your ability to perform certain activities. Please answer *every question*, based on your condition in the last week, by circling the appropriate number. If you have not had the opportunity to perform an activity in the past week, please make your *best estimate* on which response would be the most accurate. **It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.**

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

		NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1.	Open a fight or new jar.	1	2	(3)	4	5
2.	Write.	(1)	2	3	4	5
3.	Turn a key.	(1)	2	3	4	5
4.	Prepare a meal.	(1)	2	3	4	5
5.	Push open a heavy door.	1	(2)	3	4	5
6.	Place an object on a shelf above your head.	1	2	3	4	(5)
7.	Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	(5)
8.	Garden or do yard work.	1	2	3	4	(5)
9.	Make a bed.	1	(2)	3	4	5
10.	Carry a shopping bag or briefcase.	1	2	3	4	(5)
11.	Carry a heavy object (over 10 lbs.)	1	2	3	(4)	5
12.	Change a lightbulb overhead.	1	2	3	4	(5)
13.	Wash or blow dry your hair.	1	2	(3)	4	5
14.	Wash your back.	1	2	3	4	(5)
15.	Put on a pullover sweater.	1	2	3	(4)	5
16.	Use a knife to cut food.	(1)	2	3	4	5
17.	Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	(1)	2	3	4	5
18.	Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	(5)
19.	Recreational activities in which you move your arm freely (e.g., playing Frisbee, badminton, etc.).	1	2	3	4	(5)
20.	Manage transportation needs (getting from one place to another).	1	2	3	(4)	5
21.	Sexual activities.	1	(2)	3	4	5

Cottage
Rehabilitation & Sports Medicine

The DASH

DISABILITIES OF THE ARM, SHOULDER, AND HAND

Patient Name Ernest Shields Date 10/9/8

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1.	Open a tight or new jar.	1	2	(3)	4	5
2.	Write.	(1)	2	3	4	5
3.	Turn a key.	(1)	2	3	4	5
4.	Prepare a meal.	(1)	2	3	4	5
5.	Push open a heavy door.	1	(2)	3	4	5
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The DASH

DISABILITIES OF THE ARM, SHOULDER, AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, to what *extent* has your arm, shoulder, or hand problem interfered with your normal social activities with family, friends, neighbors, or groups? *(circle number)*	1	2	(3)	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder, or hand problem? *(circle number)*	1	2	(3)	4	5

Please rate the severity of the following symptoms in the last week. ***(circle number)***

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder, or hand pain.	1	2	3	(4)	5
25. Arm, shoulder, or hand pain when you performed any specific activity	1	2	3	(4)	5
26. Tingling (pins and needles) in your arm, shoulder, or hand.	1	2	3	(4)	5
27. Weakness in your arm, shoulder, or hand	1	2	3	4	(5)
28. Stiffness in your arm, shoulder, or hand.	1	2	3	(4)	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder, or hand? *(circle number)*	1	2	3	(4)	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident, or less useful because of my arm, shoulder, or hand problem. *(circle number)*	1	2	3	4	(5)

DASH DISABILITY/SYMPTOM SCORE = $\left[\frac{\text{sum of n responses}}{n} - 1\right] \times 25$, where n is equal to the number of completed responses.

A DASH score may not be calculated if there are greater than 3 missing items.

Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 785-0710
TTY: (800) 526-5812

DATE:

TO: Participating Hospitals: Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers; and Physicians

RE: Medical Services Provided to IDOC Inmates.

Effective Dec. 17, 2005, hospital providers should direct bill HFS for certain hospital services provided to inmates at IDOC facilities. These services include all Categories of service 20, 22, 24 and 29. It is the intent of HFS and IDOC to allow hospital providers to submit bills in accordance with current billing practices as outlined in the hospital handbook. Until such time as system changes are in place we are requesting that hospital providers submit bills for services rendered to IDOC inmates via the hardcopy (UB-92) method outlined in the hospital handbook.

We are requesting that when a bill is prepared, the bottom portion of this document accompanies the bill to allow HFS staff to identify and handle these claims appropriately. In the event that an HFS RIN is not available at the time of billing, please submit the fully completed hardcopy (UB-92) without the RIN and HFS will assist in assigning a correct RIN to the claim in order to process it. As soon as system changes are in place to electronically process IDOC claims all providers will be notified and the hard copy claim process will end. Hospital providers will then utilize their current system of billing.

It is the intent of HFS and IDOC to expedite payment for services rendered to IDOC inmates. It is the intent to cycle for payment once a month, all clean claims received during the month for IDOC inmates. This should allow for an average payment cycle of approximately 30 days.

Your patience and participation with this interim process is greatly appreciated.

Please mail your completed bills to (and direct any questions to):

Healthcare and Family Services
Attn: Dan Jenkins
Bureau of Rate Development and Analysis
201 South Grand Ave. East, 2nd Fl.
Springfield, Illinois 62763-0001

PH: 217-785-0710

RETURN WHEN SUBMITTING BILL TO HFS FOR PAYMENT
(To be completed by IDOC prior to arrival)

Date of Service: 10-9-08

Inmate Name (As provided by IDOC Staff): Shields, Ernest IB0160

10-13-08 Billing op Shumpy, for

Illinois Department of Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 785-0710
TTY: (800) 526-5812

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RETURN WHEN SUBMITTING BILL TO HFS FOR PAYMENT
(To be completed by IDOC prior to arrival)

Date of Service: 10/9/08

Inmate Name (As provided by IDOC Staff): SHIELDS, EARNEST

HFS RIN (if known): 950172288 SSN (if known): 328-66-7455

IDOC Site Name: Hill Corr. Center IDOC Inmate #: B66161

E-mail: hfswebmaster@illinois.gov

Cottage
Rehabilitation & Sports Medicine

765 North Kellogg Street
Galesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

DAILY TREATMENT NOTE

Patient Name: Ernest Shields

Treatment #: Refused
Date of Treatment: 10-22-08
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __ Total Service Code Units: ___
Assessment/Plan: Refused due to thinking trip was to have surgery
Signature: [signature]

Treatment #: 2
Date of Treatment: 10/28/08
Time Code/ Mins: ———
Total Timed Mins/Units: —
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __ Total Service Code Units: PT reval x1
Assessment/Plan: See PT Progress Report. D/C PT
Signature: Jan Greenline MS PT

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __ Total Service Code Units: ___
Assessment/Plan:
Signature:

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __ Total Service Code Units: ___
Assessment/Plan:
Signature:

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __ Total Service Code Units: ___
Assessment/Plan:
Signature:

Current Goals:	Met / Unmet	Measurement or New Goal:

1 Unit= 8 to 22 mins	2 Units= 23 to 37 mins	3 Units= 38 to 52 mins	4 Units= 53 to 67 mins

*Medicare based billing

Cottage
Rehabilitation & Sports Medicine

765 North Kellogg Street
Galesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

DAILY TREATMENT NOTE

Patient Name: Ernest Shields

Treatment #: Refused
Date of Treatment: 10-22-08
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __
Total Service Code Units:
Assessment/Plan: Refused due to thinking trip was to have surgery
Signature: [signature]

Treatment #: 2
Date of Treatment: 10/28/08
Time Code/ Mins: ——
Total Timed Mins/Units: —
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __
Total Service Code Units: Re-eval x1
Assessment/Plan: See PT Progress Report. D/C PT
Signature: [signature] MS PT

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __
Total Service Code Units:
Assessment/Plan:
Signature:

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __
Total Service Code Units:
Assessment/Plan:
Signature:

Treatment #:
Date of Treatment:
Time Code/ Mins:
Total Timed Mins/Units: /
Service Code: Mhp/Ice (97010) __ Unatt E-Stim (97014) __ Paraffin (97018) __ Mech Trctn (97012) __ Wpl/Fluido (97022) __
Total Service Code Units:
Assessment/Plan:
Signature:

Current Goals: Met / Unmet

Measurement or New Goal:

1 Unit= 8 to 22 mins	2 Units= 23 to 37 mins	3 Units= 38 to 52 mins	4 Units= 53 to 67 mins

*Medicare based billing

Cottage
Rehabilitation & Sports Medicine

Upper Extremity Exercise Flow Sheet

Patient Name: Ernest D. Shields

√	Activities	Reps (Type & #)/ Time	LBS/ Resist	Date: 10/20/05	Date: 10/28/05	Date:	Date:	Date:
	Upper Body Bike			Recumbent	See Progress Report			
	Manual Therapy Techniques		**Area**					
	Therapeutic Activities/ADL							
	Service Based Modalities	**Area**	**Rate**	**Level**	**Time**			
	Hot/Cold Pack							
	Mechanical Traction							
	Electrical Stim- Unat							
	Paraffin							
	Whirlpool/Fluido							
	Time Based							
	Electrical Stim- Man							
	Iontophoresis							
	Contrast Bath							
	Ultrasound							
	Supplies							
	Therapist's Initials/ Professional Title			PT	PT			

Illinois
Department of
Corrections

Rod R. Blagojevich
Governor

Roger E. Walker Jr.
Director

Hill Correctional Center / 600 Linwood Road / P.O. Box 1327 / Galesburg, IL 61401 / Telephone: (309) 343-4212 / TDD: (800) 526-0844

MEMORANDUM

DATE: October 15, 2008

TO: Infirmary Staff

FROM: Lois Lindorff, RN/HCUA

New Date & Time

Medical Furlough has been scheduled as delineated below:

NAME: Shields, Earnest NUMBER: B66161 D.O.B.- 2/19/71
DATE: 10/27/08 LEAVE TIME: 7:45 a.m.

PHYSICIAN: Dr. Miglorino/Dr. Funk
REASON FOR FURLOUGH: 2nd Visit for Physical Therapy.

LOCATION: Cottage Rehab & Physical Therapy
STREET: 765 N. Kellogg Street/ Suite 300
CITY/STATE/ZIP: Galesburg, IL 61401
PHONE NUMBER: (309) 343-3434

SAME DAY RETURN: X ADMISSION: EMERGENCY:
AMBULANCE:

1. Complete HS Report – Given to SA
2. MAR'S to Infirmary
3. Sign consent for TX/Operation Form
4. T.P./Admit to Infirmary

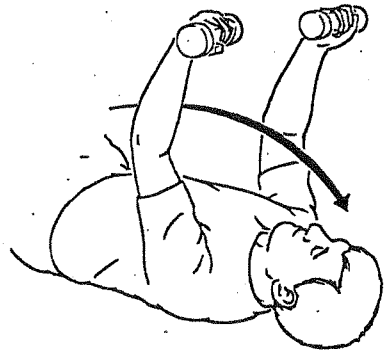
Prep Needed: **None.**

Cc: 7/3 Shift Commanders
Records Office
x-ray
medical file
file

Routine For: Ernest Shields
Created By: Cottage Rehab & SM Physical Therapy

Oct 09, 2008

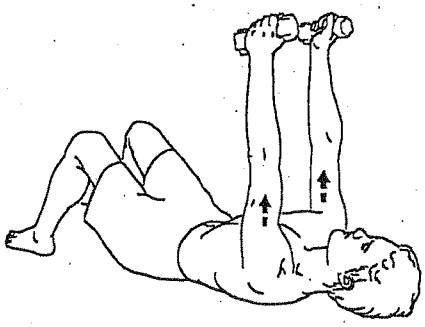
SHOULDER - 63 Progressive Resisted: Flexion (Supine)



Holding 0-1 pound weight, raise your left arm over head and lower toward floor. Go as far as possible without pain.

Repeat 20 times per set. Do 2 sets per session.
Do 1-2 sessions per day.

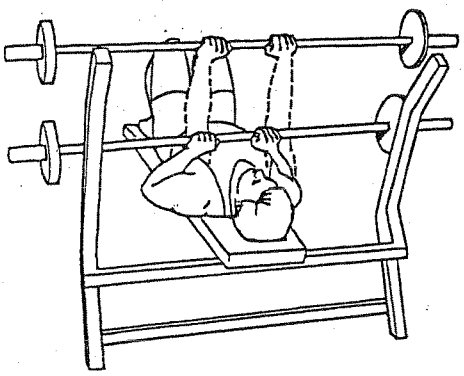
SHOULDER - 57 Scapular: Protraction – 90° of Flexion



Holding 0-5 pound weights, attempt to push arms up toward ceiling, keeping elbows straight and back against floor.

Repeat 20 times per set. Do 2 sets per session.
Do 1 sessions per day.

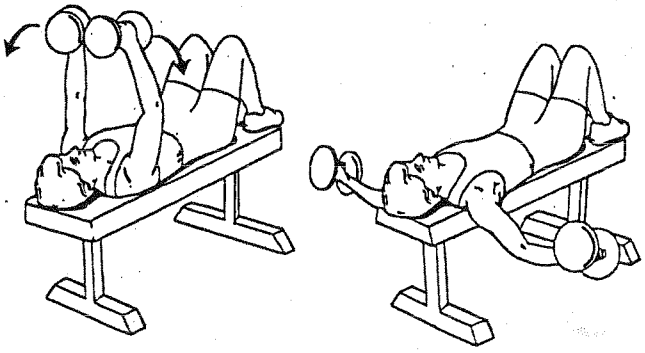
CHEST - 20 Bench Press: Narrow Grip (Barbell)



With a stick or cane in both hands, press up as in doing a bench press.

Do 2 sets. Complete 20 repetitions. Do 1-2 times per day.

CHEST - 12 Fly (Dumbbell)



Lower arms out to the side as far as comfortable and then back up.

Do 2 sets. Complete 20 repetitions. Do 1-2 sessions per day.

ICE: 15 MINUTES ON, 1 HOUR OFF

AS NEEDED FOR PAIN RELIEF AND SWELLING

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Cottage
Rehabilitation & Sports Medicine

765 North Kellogg Street
Galesburg, IL 61401
Phone: (309) 343-3434
Fax: (309) 343-3456

PHYSICAL THERAPY PROGRESS REPORT

Name: Ernest Shields Physician: Dr. Migliorino

Diagnosis: Tear of (L) Pectoralis Onset Date: 7/16/08

SUMMARY

Treatment Orders: Theex, NT, Modalities PRN

Today's Treatment: Re-assessment.

Current Complaints / Changes: The pt. reports no improvement in (L) Shoulder ROM and reports pain is worse c attempting HEP activities. He continues to state that he should believes that he needs surgery to repair the muscle.

Pain Level (0-10 Scale): 10/10 at worst Location: (L) pec min

Palpation: Diffuse marked tenderness (L) pec muscle belly c palpable tightness.

Gait: WFL.

Initial

Movement	ROM A L P	ROM A R	Strength L	Strength R
Shoulder Flexion	133°/180° guarding	164°	4+/5	5/5
" ABD	143°/180° guarding	164°	4+/5	5/5
" ER	NT/80°	NT	4+/5	5/5
" IR	NT/74°	NT	4+/5	5/5
			Flex 3+/5 !	5/5

Current

Movement	ROM A	ROM P	Strength L	Strength R
(L) Shoulder Flexion	121°	99° p!		Strength not re-assessed today 2° pain c/o
(L) Sh ABD	99°	100° p!		
(L) Sh ER	NT	84° p!		
(L) Sh IR	NT	70		

ASSESSMENT

The pts ROM is unchanged since initial eval and AROM is decreased 2° c/o pain. The pt. has been unable to progress toward PT goals for pain relief and improved ROM, 2° pain c attempted HEP performance.

PLAN

Current Goals:

	Met / Unmet	Status or Goal Upgrade:
1. (L) c HEP as appropriate	Met	Remove ≥ 4/5 (L) pec strength and ≥ 4/5 Sh flexion - 10/10 as reported
2. ↓ pain at worst to ≤ 5/10	Unmet	See above
3. Remove c-n Sh AROM	Unmet	Unable to tolerate reaching out/overhead
4. Remove functional movement of the (L) Sh pain	Unmet	

Service Dates: 10/9/08 - 10/28/08 Total Number of Visits: 2 Cert Dates: N/A

Recommendations: D/c PT at this time, 2° the pt receiving no benefit from HEP c further course of action for (L) pec tear as deemed appropriate by the MD. Thanks

Therapist Signature: Jean Landon MS, PT Date: 10/28/08

Physician Signature: _____ Date: _____

ILLINOIS DEPARTMENT OF CORRECTIONS

Medical Special Services Referral and Report

Stateville C.C.
(Facility)

Offender's Name: Shelby, Ernest ID# B66161

Reason for Referral: ☐ Consult ☐ Non-Formulary Medications ☐ Medical Equipment
☐ Evaluation ☐ Management
☐ Procedure/service (specify) ____
☑ Other (specify) ____

Urgent: ☐ Yes ☐ No

Referred to: Cottage Rehab & P.T.

Rationale for Referral: 3rd Visit for Physical Therapy.

Print Referring Practitioner's Name | Referring Practitioner's Signature | Date

Report of Referral (Use Reverse Side, if necessary)

Findings: Pt continues to demonstrate obvious injury to the (L) pec area c apparent atrophy and elicited tenderness/tightness in the (L) pec and muscle belly.

Assessment: The pt's AROM is unchanged compared to the initial evaluation. AROM is ~~not~~ decreased compared to the initial evaluation c the pt continues to c/o significant pain c AROM. Strength testing was deferred today 2° pt's pain/limited AROM.

Recommendations/Plans: The pt has not benefited from PT and has been unable to progress toward pain relief and ROM goals D/C PT at this time c further course of action re: pec injury per the MD. The pt would benefit from eval by orthopedic MD (if this hasn't been done already).

Jason Grandone | Jason Grandone MS PT | 10/28/08
Print Practitioner's Name | Practitioner's Signature | Date

Facility Medical Director Use Only

I have reviewed the recommendations and:

☐ Approve.

☐ Deny or revise as indicated on the Notification of Medical Service Referral Denial or Revision, DOC 0255.

Print Facility Medical Director's Name | Facility Medical Director's Signature | Date

Distribution: Offender, Offender's Medical File, and if denied/revised Heath Care Unit Administrator

HFS Illinois Department of Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 785-0710
TTY: (800) 526-5812

DATE: 10/28/08

TO: Participating Hospitals: Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers; and Physicians

RE: Medical Services Provided to IDOC inmates.

Effective Dec. 17, 2005, hospital providers should direct bill HFS for certain hospital services provided to inmates at IDOC facilities. These services include all Categories of service 20, 22, 24 and 29. It is the intent of HFS and IDOC to allow hospital providers to submit bills in accordance with current billing practices as outlined in the hospital handbook. Until such time as system changes are in place we are requesting that hospital providers submit bills for services rendered to IDOC inmates via the hardcopy (UB-92) method outlined in the hospital handbook.

We are requesting that when a bill is prepared, the bottom portion of this document accompanies the bill to allow HFS staff to identify and handle these claims appropriately. In the event that an HFS RIN is not available at the time of billing, please submit the fully completed hardcopy (UB-92) without the RIN and HFS will assist in assigning a correct RIN to the claim in order to process it. As soon as system changes are in place to electronically process IDOC claims all providers will be notified and the hard copy claim process will end. Hospital providers will then utilize their current system of billing.

It is the intent of HFS and IDOC to expedite payment for services rendered to IDOC inmates. It is the intent to cycle for payment once a month, all clean claims received during the month for IDOC inmates. This should allow for an average payment cycle of approximately 30 days.

Your patience and participation with this interim process is greatly appreciated.

Please mail your completed bills to (and direct any questions to):

Healthcare and Family Services
Attn: Dan Jenkins
Bureau of Rate Development and Analysis
201 South Grand Ave. East, 2nd Fl.
Springfield, Illinois 62763-0001

PH#: 217-785-0710

RETURN WHEN SUBMITTING BILL TO HFS FOR PAYMENT
(To be completed by IDOC prior to arrival)

Date of Service: 10/28/08

Inmate Name (As provided by IDOC Staff): Shields Earnest

HFS RIN (if known): 950172288 SSN (if known): 328-66-7455

IDOC Site Name: Hill Corr. Center IDOC Inmate #: B66161